North End COMMUNITY HEALTH CENTRE MOSH

MOSH O.T. REFERRAL FORM

MOSH Tel: 902.429.5290 - Fax: 902.422.0859
2131 Gottingen St. Halifax, Nova Scotia (Entrance in back of the building)

Referral Pre-requisites: Consent for referral: Y/N Housing Vulnerability: Y/N

Name: **DOB:** **Gender pronouns:**

If known, HCN: **Family Physician:**

Health Status/History:

Housing Status/History:

Requesting: ☐ Individual ☐ Group ☐ Consultation (to staff) ☐ Health Promotion (event/ program)

Reason for referral: (Check all that apply, if can be expected modifiable by OT involvement)

- ☐ Personal Care
- ☐ Property/ Home Mgt
- ☐ Shelter/ Tenancy Demands
- ☐ Mobility Falls
- ☐ Community Engagement
- ☐ Budget/ Financial Mgt
- ☐ Shop/ Errands/ Transport
- ☐ Skills/ Deficit Evaluation
- ☐ Health/ Meds/ Symptom Mgt
- ☐ School/Learning/Work
- ☐ Meal Prep/Food Security
- ☐ Writing/ Communication
- ☐ Parenting/ Caregiving
- ☐ Environmental Assessment
- ☐ Discharge/Transition Planning
- ☐ Client/Staff Education: (Health info, Strategies, Prevention, etc.)
- ☐ Leisure/Play/Volunteer
- ☐ Developmental Milestones
- ☐ Behavioural/Mental Health
- ☐ Cognitive/Perceptual
- ☐ Social/ Interpersonal
- ☐ Physical
- ☐ Other:

What do you hope to achieve with OT involvement?

List Other Supports in Place & Contact Info: (housing, health/social workers, guardian, trustee etc.)

Other Considerations: (literacy, precautions, etc.)

Method to Initiate OT Involvement:

☐ Contact client directly (Info/Method): ☐ Contact referral source/other (Info/Method):

Referral Source: **Tel:** **email:** **Date:**

Involvement with client:

Triage: Priority General **Relevant Deadlines** (discharge, eviction):

MOSH USE ONLY

Date referral received: Wait time (days) to first attempted contact:

Time between initial contact and discharge (days): Date discharged:

Reason for discharge (see codes):